Screen Date Early and Periodic	West Virginia Department of Health and Human Resources Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen					15 Month Form	
Name		DOB		Age	Sex	: 🗆 M 🗆 F	
Weight Length Weight for Length	HC Pulse	BP (optional)	Resp	Temp	Pulse Ox (optional)_		
Allergies NKDA							
Current meds ☐ None							
□ Foster child □	Kinship placement	CI	hild with special heal	th care needs			
Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐	Foster organization		Dothe	er			
Medical History ☐ Initial screen ☐ Periodic screen ☐ Family health history reviewed	☐ Relationships (partner, famil	y and/or friends) ☐ School/work	Is it hard to ke ☐ Not at all (0 Is it hard to pu	hard to keep your child on a schedule or routine? Iot at all (0) □ Somewhat (1) □ Very much (2) hard to put your child to sleep? Iot at all (0) □ Somewhat (1) □ Very much (2)			
Parental history of postpartum depression ☐ Yes ☐ No In utero substance exposure ☐ Yes ☐ No Maternal Hep C exposure ☐ Yes ☐ No	emotional and/or sexual) ☐ Fa		Is it hard to go In Not at all (0) Does your chi	Is it hard to get enough sleep because of your child? □ Not at all (0) □ Somewhat (1) □ Very much (2) Does your child have trouble staying asleep? □ Not at all (0) □ Somewhat (1) □ Very much (2) Subscale 3 score			
Child recent injuries, surgeries, illnesses, visits to other providers and or hospitalizations:	Baby Pediatric Symptom Checklist (BPSC) *Positive screen = numbered responses 3 or greater in <u>any</u> of the 3 subscales. Further evaluation and/or investigation may be needed.		Development Social Langu (point to comm	Developmental Developmental Surveillance (Check those that apply) Social Language and Self-help *Child can prodeclarative point (point to comment on an interesting object/event-will look alternative)			
Psychosocial/Behavioral What is your family's living situation?	Subscale 1 (✓ Check one for e Does your child have a hard tin Not at all (0) □ Somewhat	me being with people? (1) □ Very much (2)	something to like "Where's	between object/event and parent) ☐ Child can point to something to get help ☐ Child can look around when like "Where's your ball?" or "Where's your blanket?" ☐ imitate scribbling ☐ Child can drink from a cup with lit			
Family relationships □ Good □ Okay □ Poor Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? □ Yes □ No	Does your child have a hard tin ☐ Not at all (0) ☐ Somewhat Does your child have a hard tin ☐ Not at all (0) ☐ Somewhat	(1) ☐ Very much (2) ne with change?	Verbal Langu words other the unknown lang	Verbal Language (Expressive and Receptive) ☐ Ch words other than names ☐ Child can speak in sound unknown language ☐ Child can follow directions that		ean use 3 e an	
Do you have concerns about meeting basic family needs daily and/o monthly (food, housing, heat, etc.)? ☐ Yes ☐ No	Does your child mind being hel ☐ Not at all (0) ☐ Somewhat ☐ Subscale 1 score	(1) ☐ Very much (2)	Gross Motor up a few step	gesture Gross Motor □ Child can squat to pick up objects □ Cup a few steps □ Child can run Fine Motor □ Child can make marks with a crayon □			
Who do you contact for help and/or support?	Subscale 2 (✓ Check one for e	each question)		⊐ Child can make ma nd take object out of	•	ппа сап агор	
Are you and/or your partner working outside home? ☐ Yes ☐ No Child care_	Does your child cry a lot? ☐ Not at all (0) ☐ Somewhat Does your child have a hard tin	(1) Uery much (2)	*Absence of	these milestones =			

□ Not at all (0) □ Somewhat (1) □ Very much (2)

□ Not at all (0) □ Somewhat (1) □ Very much (2)

□ Not at all (0) □ Somewhat (1) □ Very much (2)

Is your child fussy or irritable?

Is it hard to comfort your child?

Subscale 2 score _

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

☐ Drugs (prescription or otherwise)_

☐ Access to firearm(s)/weapon(s)

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? \square Yes \square No Do you think your child hears okay? \square Yes \square No

Continue on page 2



Screen	Data		
oci ee ii	Date		

15 Month Form, Page 2

Name		DOB	Age Sex: 🗆 M 🔻
Oral Health		Hips □ N □ Abn	Plan of Care
Date of last dental v	risit	Extremities	Assessment
Current oral health	problems		☐ Well Child ☐ Other Diagnosis
Water source ☐ P	ublic □ Well □ Tested	Signs of Abuse/Neglect ☐ Yes ☐ No	-
• •	tation □ Yes □ No		Immunizations
	olied (apply every 3 to 6 months)		□ UTD □ Given, see immunization record □ Entered into WVSIIS
☐ Yes ☐ No		_	
		Age Appropriate Health Education/Anticipatory	Labs
Nutrition/Sleep		Guidance (Consult Bright Futures, Fourth Edition. For further	☐ Hemoglobin/hematocrit (if high risk)
☐ Breastfeeding - F	requency	information: https://brightfutures.aap.org)	☐ Blood lead (if high risk) (enter into WVSIIS)
	mount Frequency	Communication and Social Development, Sleep Routines and	□ Other
		Issues, Temperament, Development, Behavior, and Discipline,	
Plans for weaning_		—— Healthy Teeth, and Safety	Deferrele
☐ Milk ☐ Juice ☐		☐ Discussed ☐ Handouts Given	Referrals
☐ Normal eating ha	ibits		☐ Developmental ☐ Dental
☐ Vitamins		Questions/Concerns/Notes	□ Other
□ Normal eliminatio		—	
☐ Normal sleeping	patterns		☐ Birth to Three (BTT) 1-800-642-9704
			☐ Children with Special HealthCare Needs (CSHCN)
	noglobin/Hematocrit)		1-800-642-9704
☐ Low risk ☐ Hig	h risk		─ ☐ Women, Infants and Children (WIC) 1-304-558-0030
*Lead Risk			_
☐ Low risk ☐ Hig	h risk		Medical Necessity
*See Periodicity Se	chedule for Risk Factors		For treatment plans requiring authorization, please complete
			page 3. Contact a HealthCheck Regional Program Specialist for
Physical Exami	nation (N=Normal, Abn=Abnormal)		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
•	e □N □Abn		_
Skin	□ N □ Abn		_
Neurological	□ N □ Abn		Follow Up/Next Visit □ 18 months of age
Reflexes	□ N □ Abn		☐ Other
Head	□ N □ Abn		
Neck	□ N □ Abn		_
Eyes	□ N □ Abn		─ □ Screen has been reviewed and is complete
Red Reflex	□ N □ Abn		_
Ocular Alignment	□ N □ Abn		_
Ears	□ N □ Abn		_
Nose	□ N □ Abn		_
Oral Cavity/Throat	□ N □ Abn		
Lung	□ N □ Abn		_
Heart	□ N □ Abn		Please Print Name of Facility or Clinician
Pulses	□ N □ Abn		
Abdomen	□ N □ Abn		
Genitalia	□ N □ Abn		
Back	□ N □ Abn		Signature of Clinician/Title